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Statement of
Congressman Jim **Greenwood**
before the
Committee on **Commerce**
Subcommittee on Health and the Environment
of the United States House of Representatives
on
Provider-Sponsored-Organizations

Accompanied by Mr. Rich Rief
President and CEO, Doylestown Hospital

March 19, 1997

We have declared as a top priority -- the need to reform and safeguard the future of the Medicare program. Given our commitment to balancing the budget within this context, the use of coordinated care under the Medicare program is being encouraged by the Administration and this Congress. For Medicare beneficiaries, choice of plans and the ability to choose local providers are critical. I am testifying before you today as a Subcommittee member and sponsor of a Medicare provider-sponsored-organization bill to amplify my conviction that PSOs can help meet *both* the cost containment objectives envisioned in the federal budget process *and* the **need** for beneficiaries to have greater choice and greater quality.

Provider-sponsored organizations are not a new concept. The House and Senate successfully passed PSO legislation in the 104th Congress with broad support. Little opposition exists to expanding Medicare's managed care options to include PSOs. However, agreement on the standards for PSO participation have been more elusive.

That is why we are here today. You will hear testimony from the indemnity insurers who want (quote) "a level playing field." Their opposition will be undeviating. You will also hear testimony from the providers and hospitals who will argue that PSOs should be held to

requirements that are sensitive to the many differences between PSOs and HMOs. Needless to say, I agree. Such Medicare requirements should reflect, for example, that PSOs are the direct providers of care; not the insurers who purchase the care.

The NAIC will testify about its efforts to develop a model uniform standard for all managed care plans, which some may argue, provides a sound reason for Congress **not** to take action on PSOs. I commend the NAIC and encourage the completion of this model. The problem is that we are reforming Medicare now. We are balancing the budget **now.** PSO legislation is a federal, temporary measure that is **essential** if we encourage vigorous managed care enrollment in Medicare in order to control costs and reap the savings necessary to balance the budget.

A provider-sponsored-organization will testify on behalf of the managed care community to demonstrate that PSOs can effectively enter the market. Yes, they can -- and Mr. Rief, President of Doylestown Hospital in my district, can also vouch for their success. Mr. Rief has developed several PSO versions like this. Understand though, that for a PSO to be successful in the current market, it must either contract with large self-employed groups or partner with a managed care company. Not all providers - particularly in underserved and rural areas - have the infrastructure and resources necessary to reconfigure themselves to look like an insurance company. In addition, partnering with an insurance company will not necessarily save Medicare dollars. Let me tell you why. I'll give you two real world examples.

Mr. Rief's hospital and medical staff created the Bucks County Physician Hospital Alliance in 1989 with the specific intent to coordinate patient care. Because of state requirements, his PSO has only been able to provide health services to two large self-insured employers, most notably the Central Bucks School District. In the past four years the physician/hospital plan called Doylestown Choice has enrolled 489 members and their families, and saved the school district $3,332,000. The PSOs savings are the result of an enrollment reduction in an indemnity insurer whose profits and overhead were estimated to be in the 30% range, and for the physicians, hospital and school district's efforts to carefully coordinate the patient's care.

I have another PSO in my district that contracts with an insurer. PennCARE is a regional

network of 9 hospitals and medical staff -- established after extensively negotiating with a managed care company -- that provides all patient care at financial risk for more than 80,000 covered lives. For the Medicare lives covered, the managed care company receives 95% of the AAPCC; but pays its providers at much lower rates. The managed care company benefits from 20% to 25% in profits and overhead. Putting this into a Medicare context, without provider access to Medicare recipients, many dollars would be drained from the Medicare program by the insurer. PSOs that contract with Medicare directly can save money that would otherwise remain with the insurer as profit and overhead. The savings don't necessarily materialize when a PSO is partnered with an insurer.

If we are to truly solve the Medicare crisis we need fundamental change, not only in the amount of financing but in the way care is paid for and provided. This is why we need PSO legislation with federal regulation.

There are so many things I want to share with you about PSOs and the merits of our bill. Since we have a number of witnesses anxiously waiting to give their testimony today, let me just leave you with a few thoughts.

First: PSOs must have federal standards for the first few years because seniors -- who rely on the federal Medicare program -- should have a federal guarantee of quality and solvency. This does not mean fewer standards or lower standards -- it means uniform standards. Rather than relying on highly variable and often limited state requirements, these federal standards assure that state-of-the art quality improvement processes will be available across the country for Medicare beneficiaries who choose the PSO option.

Second: Be clear that we are examining the regulatory nature of PSOs only in relation to the Medicare population. Proponents are not asking for special standards for the commercial market. What we are talking about is devising federal standards for the federal Medicare program.

Third: The Administration, this Congress, and even this Subcommittee has begun to focus on

quality of care -- especially in the Medicare program. Given this precedent, successful Medicare PSO legislation demands experience. Congress will not allow providers to enter the Medicare market who are inexperienced or who cannot meet high quality and solvency requirements. Again, to **ensure** this, federal, uniform standards are critical.

Fourth: To an extent, the debate over PSO regulation echoes the debates of the early 1970s when HMOs were just beginning to evolve -- but couldn't get into the market. HMOs sought relief from state insurance laws because state solvency requirements were seen as excessive and unappreciative of the unique resources available to them. In their view, these laws needed to be superseded by federal requirements that would encourage proliferation -- as opposed to creating a barrier to market. The outcome of this debate was the Health Maintenance Organization Act of 1973, which enabled HMOs meeting federal requirements to be exempt from specific state laws. specifically laws that required the HMO to meet the state solvency requirements.

As of February 1, 1997, nearly 5 million beneficiaries were enrolled in a total of 336 managed care plans. This accounts for only 13 percent of the Medicare population. As Congress and the Administration compromise on a Medicare reform plan that encourages managed care in the name of cost containment and balancing the budget -- it is essential that Medicare offer more choices. As managed care grows and as providers integrate and establish coordinated care organizations, Medicare beneficiaries should have the opportunity to receive their health care services from a locally-based provider-operated health plan. I am extremely pleased to have introduced **bipartisan** legislation, with my colleague Mr. Stenholm, that will give Medicare beneficiaries the opportunity to receive their health care services from a locally-based, provider health care plan.

Crafting legislation requires accommodation. Our bill takes a middle of the road approach that builds on last year's compromises. We have met with, and continue to meet with providers. hospitals, insurers and managed care plans to seek their guidance and request their input. All of the major budget proposals, both Democrat and Republican, contained PSO language. This alone, is indicative of the fact that we need to expand the range of coordinated care choices in the Medicare program if we are going to save it for future generations.

Thank you for your time and attention.